Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH RUNNELS HOSPITAL
PO BOX 185
WINTERS TX 79567

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-1123-02

MFDR Date Received
November 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "W/C could not see patient. Enclosed letter states for patient to come to North Runnels emergency room."

Amount in Dispute: $2,642.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As indicated by its EOBs Texas Mutual believes no further payment is due"

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 12 – 14, 2009	Outpatient Hospital Services	$2,642.31	$757.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 618 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE
   - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER

RECONSIDERATION

- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   The insurance carrier denied disputed services with reason code, 225 – "THE SUMBITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION." Review of submitted information finds in the EMERGENCY ROOM PATIENT RECORD "Set up for nerve block by Dr. S. Endicott." Also in EMERGENCY ROOM PHYSICIAN'S NOTES, "Nerve block" was administered to improve pain control. Therefore, this service will be reviewed per applicable rules and fee guidelines.

   - Procedure code 64475, date of service January 12, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $473.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $284.27. This amount multiplied by the annual wage index for this facility of 0.8408 yields an adjusted labor-related amount of $239.01. The non-labor related portion is 40% of the APC rate or $189.51. The sum of the labor and non-labor related amounts is $428.52. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $428.52. This amount multiplied by 200% yields a MAR of $857.04.
   - Per Medicare policy, procedure code 96372, date of service January 12, 2009, may not be reported with procedure code 99283 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 99283, date of service January 12, 2009, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of $136.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $82.02. This amount multiplied by the annual wage index for this facility of 0.8408 yields an adjusted labor-related amount of $68.96. The non-labor related portion is 40% of the APC rate or $54.68. The sum of the labor and non-labor related amounts is $123.64. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $123.64. This amount multiplied by 200% yields a MAR of $247.28.
   - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the

applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.36. 125% of this amount is $15.45

- Procedure code 81000 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.63. 125% of this amount is $5.79
- Procedure code 82550 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.51. 125% of this amount is $11.89
- Procedure code 83735 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.78. 125% of this amount is $12.22
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19
- Procedure code 93041, date of service January 13, 2009, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0035, which, per OPPS Addendum A, has a payment rate of $14.44. This amount multiplied by 60% yields an unadjusted labor-related amount of $8.66. This amount multiplied by the annual wage index for this facility of 0.8408 yields an adjusted labor-related amount of $7.28. The non-labor related portion is 40% of the APC rate or $5.78. The sum of the labor and non-labor related amounts is $13.06. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $13.06. This amount multiplied by 200% yields a MAR of $26.12.
- Procedure code 93041 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0035, which, per OPPS Addendum A, has a payment rate of $14.44. This amount multiplied by 60% yields an unadjusted labor-related amount of $8.66. This amount multiplied by the annual wage index for this facility of 0.8408 yields an adjusted labor-related amount of $7.28. The non-labor related portion is 40% of the APC rate or $5.78. The sum of the labor and non-labor related amounts is $13.06. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $13.06. This amount multiplied by 200% yields a MAR of $26.12.

3. The total allowable reimbursement for the services in dispute is $1,216.10. This amount less the amount previously paid by the insurance carrier of $458.99 leaves an amount due to the requestor of $757.11. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $757.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $757.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October 2, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.